Knee pain in children

Maa Stelly Tennant BSc MBBS FRCS FRCS (Tr and Orth) is a paediatric orthopaedic surgeon at Bupa Cromwell Hospital, St Mary’s Hospital, and the Royal National Orthopaedic Hospital.

Mr Chirman Gupte MA PhD FRCS (Tr and Orth) BMBCh is a paediatric knee and trauma surgeon at Bupa Cromwell and St Mary’s Hospitals.

Knee pain in children can have a multitude of causes, but it is important to be aware that hip pathology such as Perthes disease and slipped upper femoral epiphysis can be present in children with knee pain. These conditions can lead to a dangerous delay in diagnosis as a delay in treatment of these conditions can result in joint destruction and permanent disability.

This article is intended to give a brief overview of some of the more common causes of knee pain in children, but it should be used as a guide only. Please refer to a doctor if you suspect a diagnosis of knee pain.

This article is intended to give a brief overview of some of the more common causes of knee pain in children, but it should be used as a guide only. Please refer to a doctor if you suspect a diagnosis of knee pain.

**Tumours**

Tumours are the only condition where the pain can be associated with the normal pain of the knee. The presence of a tumour is the one condition where the pain is due to a mass effect on the knee. Malignant tumours, specifically Ewing’s sarcoma, can be seen on bone scans and MRI imaging. It is rare for a tumour to be present in a child’s knee, but it is important to be aware of this possibility.

**Reactive arthritis and inflammatory arthritis**

As an adult, reactive arthritis can occur in children, complicating viral infections. The differential diagnosis is septic arthritis and inflammatory arthritis. The rash can be a clear sign of a preceding viral infection. Inflammatory arthritis usually has a chronic presentation with a limp more common than acute pain. Discomfort is typically felt as morning stiffness, or stiffness after prolonged periods of immobility. Children are often able to undertake strenuous activity later in the day. A warm environment improves symptoms. Other joints may be involved. Examination often reveals synovial thickening in the suprapatellar pouch with muscle wasting and possibly an effusion (see Figure 3).

**Anterior knee pain and patello-femoral maltracking**

Anterior knee pain and patello-femoral maltracking are common complaints in children. The pain is usually felt in the front of the knee and is often associated with a feeling of instability. The treatment is usually a combination of rest, physiotherapy, and medication. Children who have a history of previous knee surgery or who have a history of patellar dislocation are at increased risk of developing anterior knee pain.

**Conservative management**

Conservative management is the treatment of choice for most children with knee pain. This includes rest, physiotherapy, and medication. Children who have a history of previous knee surgery or who have a history of patellar dislocation are at increased risk of developing anterior knee pain.

**Surgery**

Surgery is usually only performed if conservative management fails. The common surgical procedures include anterior cruciate ligament reconstruction, medial patello-femoral ligament reconstruction, and osteotomy.

**Conclusion**

Knee pain in children is a common complaint that can have a multitude of causes. It is important to be aware of the common causes and to consider the possibility of more serious conditions such as Perthes disease and slipped upper femoral epiphysis. A differential diagnosis should be considered and appropriate investigations should be performed to identify the cause of the knee pain.

Figure 1. Plain radiograph of the pelvis showing a slipped femoral epiphysis. This is a common cause of knee pain in children (but not including bony injuries which are beyond the scope of this short article). Knee pain is commonly attributed to "growing pains" which should really only be a diagnosis of exclusion and only if the symptoms fit a fairly classical chronic and intermittent pattern of usually night pain with no other disturbance.

Figure 2. Plain radiograph showing the classic appearance of an osteoid ostema in the proximal femur which presented as knee pain.

Figure 3. Clinical picture showing synovial thickening and effusion of the suprapatellar pouch in the left knee compared with the normal right knee.

Cookie Settings

This site uses cookies to store information on your computer, to improve your experience. One of the cookies this site uses is essential for parts of the site to operate and has already been set. You may delete and block all cookies from this site, but parts of the site will not work. To find out more about the cookies this site uses and how to delete them, please see the privacy notice.

I accept cookies from this site.

Continue
Anterior knee pain is very common and is at the mildest end of the spectrum of patello-femoral symptoms, the most severe of which is patellar subluxation and dislocation. Anterior knee pain describes pain which is felt around and under the patella, is worse following prolonged periods of sitting (otherwise known as cinema knee) and on climbing stairs. It is most common in adolescent girls and is usually improved or cured by VMO (vastus medialis oblique) strengthening exercises which aim to realign the strong lateral pull of the vastus lateralis on the patella.

At the other end of the spectrum is recurrent dislocation and subluxation. These patients require referral as there are often underlying soft tissue or bony abnormalities.

**Osgood-Schlatter's disease**

Osgood-Schlatter's disease is a disorder of the formation and growth of the proximal tibial apophysis occurring in adolescents during the time of its ossification. Patients present with anterior knee pain centered over the tibial tubercle which comes on with exercise, with focal tenderness and swelling at this point. It is relieved by rest. X-rays show fragmentation of the apophysis, but are not necessary to make the diagnosis as it is usually obvious clinically. Treatment is symptomatic with rest, ice, analgesia and sometimes physiotherapy. Cessation or reduction of sporting activities depends on the individual patient and their pain level.

**Osteochondritis dissecans**

This condition is caused by necrosis of a focal area of subchondral bone, most commonly affecting the lateral part of the medial femoral condyle. When the overlying cartilage loses its supporting structure, a fragment may be displaced into the joint as a loose body. Repetitive micro-trauma is thought to be an important initiating factor. Symptoms are chronic, often vague and include activity related pain, stiffness after rest, catching or giving way.

Radiographs are usually diagnostic if 'tunnel views' are obtained (see Figure 4). An MRI scan is used to assess severity and guide treatment. In general, girls <11 and boys <13 years can be managed conservatively and will often settle with a period of restriction of activity. In older children the prognosis is more guarded and arthroscopy is usually indicated, when the lesion can be drilled to encourage healing, reattached, or loose bodies removed.

**Soft tissue knee injuries**

Sporting injuries in children are becoming increasingly common with participation in aggressive and competitive sports occurring at a younger age.

Immediate swelling following an injury is highly suggestive of a haemarthrosis; caused by either a tear within the joint capsule, or an intra-articular ligament rupture such as the anterior cruciate ligament. The delayed onset of an effusion (two hours plus) following injury is more suggestive of a meniscal tear.

Plain radiographs are important to exclude a bony injury, at the very least AP and lateral views, and if a patellar dislocation is suspected then skyline views as well. If these are normal, immediate management should include a turbgrip, crutches, ice, analgesia and anti-inflammatory and early specialist review.

Depending on the persistence of symptoms and signs, an MRI scan may be indicated.

**Acute patella-femoral dislocations (Figure 5)**

Acute dislocation of the patella is often a painful, trauma-related event. Urgent referral is required. Reduction can most often be performed closed with anaesthesia and sedation, but can sometimes require general anaesthetic or operation, particularly if there is avulsion of a bony fragment from the medial facet of the patella or the lateral condyle of the femur.

After reduction the knee will be immobilised in a brace or occasionally in plaster. Physiotherapy is started early in order to minimise muscle wasting.

**Anterior cruciate ligament injury**

Although ACL injuries are less common in children than adults – one percent of all ACL injuries occur in children – they must not be overlooked.

Most injuries occur during sport and are often the result of abnormal twisting, landing or hyperextension.

Assessment is as for adult injuries. However, studies have shown a poor prognosis for the conservatively managed paediatric ACL rupture, probably due to an increased risk of medial meniscal injury in the unstable knee, which in turn increases the risk of early degenerative arthritis. Thus, the management approach is somewhat more aggressive in children, and even children with relatively minor symptoms should be counselled to consider ACL reconstruction. In those approaching skeletal maturity, surgical reconstruction can use techniques as for adult injuries. However a problem occurs in young children because these conventional techniques would involve the placing of hardware in tunnels across the physis (growth plates) increasing the risk of growth arrest.

In these young children alternative methods of reconstruction are required. It is our opinion that reconstruction should be performed in dedicated paediatric units by experienced surgeons in order to minimise the risks of failure and of growth disturbance. Pre and post-operative physiotherapy are vital to ensure successful rehabilitation.
Meniscal tears

As with ACL injuries, meniscal injuries are less common in children than adults. They most often result from a twisting injury to the knee, and are more common when the ACL has been injured. Approximately 0.5 - 1% of children have a structural predisposition to lateral meniscal tear known as a discoid lateral meniscus which is thicker and covers more of the tibial plateau than it should do – normally a semi-lunar shape (see Figure 6). Symptoms include visible and palpable "dunking" and sometimes pain, particularly if torn. The incidental finding of a discoid meniscus, for example on an MRI scan done for other reasons, does not require any intervention. However, symptoms of pain, or the presence of a tear usually requires arthroscopic debridement +/- meniscal repair.

Some peripheral tears of the meniscus have the potential to heal with conservative management and restriction of activity, however most will require operative intervention with arthroscopy. The aim is to preserve as much of the meniscus as possible by suturing, as children's menisci have a good potential to heal and avoiding a large section of the meniscus can predispose to early degenerative changes. This decision can only be made at operation. Concurrent reconstruction of an injured ACL seems to confer a positive prognosis for healing of repaired menisci, improving success rates from 75 to 85 percent.

Rehabilitation includes bracing and specialised physiotherapy and again we feel that these procedures should take place in dedicated units experienced in paediatric knee surgery.

For further information about our services please contact our GP Liaison Team on +44 (0)20 7460 5973.